

BATTLE FOR BENEFITS

VA Discrimination Against Survivors of
Military Sexual Trauma



Photo: The U.S. Army

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EXECUTIVE SUMMARY

Sexual assault and harassment are serious problems in the United States armed forces that threaten the strength, readiness, and morale of the military, undermine national security, and have devastating personal effects on survivors and their families. Less well known is the second battle that many veterans who survive sexual violence must fight with the U.S. Department of Veterans Affairs (VA) when they return to civilian life. The process of obtaining VA disability benefits for the enduring mental health effects of military sexual trauma (MST)¹ is an unfair fight in which veterans are often unsuccessful. They face a broken bureaucracy, with protracted delays and inaccurate adjudications. And based on records that VA has withheld until now, it is clear that veterans who survive in-service sexual trauma also face discrimination in seeking compensation.

This report presents the first opportunity for veterans, policy-makers, and the public to examine in detail the experiences of MST survivors as they seek compensation from VA. It is based on data provided by VA in settlement of two Freedom of Information Act lawsuits.² The lawsuits were brought by the Service Women's Action Network, ACLU Women's Rights Project, and the ACLU of Connecticut, with the Veterans Legal Services Clinic at Yale Law School serving as lead counsel. As a result of these settlements, VA handed over never-before-released data on mental health disability benefit claims filed by veterans suffering from the aftermath of rape, sexual assault, and sexual harassment.

These data offer a close look at the enduring health consequences and bureaucratic battles that survivors of in-service³ sexual trauma face as they transition back to civilian life. Notably, the data reveal that VA has granted disability claims for Post-Traumatic Stress Disorder (PTSD) caused by in-service sexual trauma at significantly lower rates than it has granted claims for PTSD arising from other causes. Moreover, the data also reveal dramatic variation among VA regional offices in the treatment of MST-related mental health claims and disparate treatment by gender.

Key Findings

- VA granted disability benefit claims for PTSD related to MST at a significantly lower rate than claims for PTSD unrelated to MST every year from 2008 to 2012. The grant rate for MST-related PTSD claims has lagged behind the grant rate for other PTSD claims by between 16.5 and 29.6 percentage points every year.
- For claims for disability benefits based on either of two other mental health conditions—major depressive disorder⁴ and anxiety disorder not otherwise specified⁵—there is minimal disparity between the rates at which VA granted MST-related claims and claims unrelated to MST.
- Because female veterans' PTSD claims are more often based on MST-related PTSD than male veterans' PTSD claims, female veterans overall are disparately impacted by the lower grant rates for MST-related PTSD. For every year between 2008 and 2011, a gap of nearly ten percentage points separated the overall grant rate for PTSD claims brought by women and those brought by men.
- Among those who file MST-related PTSD claims, male veterans face particularly low grant rates when compared to female veterans who file MST-related PTSD claims.

- Treatment of MST-related PTSD claims varies widely from one VA regional office (VARO) to another. The VAROs that discriminated most egregiously in 2012 include those in St. Paul, MN; Detroit, MI; and St. Louis, MO.

This report examines VA statistical records, highlighting these and other findings of immediate use to policy-makers and veterans' advocates, and recommending policy and legislative reforms. Key recommendations include:

- reforming VA regulations on disability claims based on PTSD related to in-service assault;
- improving training and oversight of VA offices with poor records in granting MST claims; and
- enhancing VA transparency and record keeping related to MST-based disability claims.

Congress should act swiftly to enact important legislation that addresses these pressing concerns. MST survivors have waited long enough.

I. INTRODUCTION

A. *VA Disability Benefits*

As a matter of policy—if not always practice—VA is committed to providing “compensation to [v]eterans who are at least 10% disabled because of injuries or diseases that occurred or were aggravated during active military service.”⁶ VA awards benefits on a sliding scale based on the extent of a veteran's disabilities. Over 3.3 million veterans with service-connected disabilities rely on VA disability benefits to supplement their limited earnings or, in some cases, wholly replace lost income.⁷ Many depend on these disability payments to meet their most basic needs like food, rent, and transportation.

A veteran must apply to VA in order to secure disability benefits, and the application process is typically neither quick nor easy. First, the veteran must apply by making a disability benefits claim to his or her local VA regional office (VARO), one of 56 in the nation.⁸ The veteran must prove that he or she suffers from a disabling medical condition, that the medical condition is related to a claimed stressor, and that the stressor is connected to the veteran's military service. By statute, VA has a duty to help the claimant assemble evidence, including records from federal agencies and private medical facilities.⁹ If there is sufficient evidence, VA must provide a current medical examination, called a “Compensation and Pension” exam.

If the regional office denies the veteran's claim, the veteran can appeal to the Board of Veterans' Appeals (BVA). If the BVA denies the claim on appeal, the veteran can further appeal to the U.S. Court of Veterans Claims, an Article I court in Washington, DC that frequently remands cases based on a VA procedural or substantive error. A veteran may appeal further to the U.S. Court of Appeals for the Federal Circuit. A claim may cycle through this appeals process many times.

As even this basic description illustrates, the application process can be very lengthy and often unnecessarily so. The average time that a veteran waits for a VARO decision is 260 days.¹⁰ A veteran choosing to appeal to the BVA faces an average wait time of three-and-a-half years.¹¹ The length of this process is due not only to the numerous steps and reviewing bodies that many

claims pass through, but also to an extreme backlog in claims processing at the VARO level.¹² As of November 2, 2013, the VARO backlog was over 400,000 claims.¹³

Inaccuracy in the adjudication process is also a major flaw. The leader of the American Legion, a veterans' service organization, testified in September 2013 that his review teams have found error rates of 66% in certain regional offices.¹⁴ VA performance metrics that reward claims processors solely based on the number of claims they process, a strategy developed to reduce the backlog, may be partially to blame. Whatever the underlying reasons, when VA delays or erroneously denies claims, disabled veterans suffer needlessly.

B. The Battle for VA Disability Benefits for Mental Health Conditions Resulting from Military Sexual Trauma

When a veteran suffers from invisible but debilitating psychological wounds as a result of MST, the battle for VA disability benefits is especially difficult. In-service sexual trauma can result in long-term mental health conditions such as PTSD, major depressive disorder, and anxiety disorders; these conditions can complicate veterans' transitions back into civilian life, decrease veterans' work capacity or productivity, and lead to homelessness, substance abuse, and family and marital problems.¹⁵ VA provides screening and medical care for mental health conditions and for military sexual trauma. However, care without compensation is not enough for MST survivors whose debilitating mental health conditions prevent them from building fully productive careers after their service.

Proving "service connection" in order to secure disability benefits for mental health conditions like PTSD can be especially difficult for survivors of MST. This is true not only because these survivors' wounds are invisible, but also because the evidentiary standard that MST survivors must satisfy ignores the realities and unique circumstances surrounding military sexual trauma. VA has adopted regulations to ease the burden of proof for veterans with PTSD resulting from combat, POW status, and most recently, "fear of hostile military or terrorist activity;" however, VA has not done so to the same extent for veterans with PTSD arising from MST.¹⁶ For survivors of in-service sexual trauma, lay testimony is often insufficient to prove the occurrence of the trauma. These veterans must also present corroborating evidence of their sexual trauma. Because systemic under-reporting of in-service sexual trauma often limits the amount of documentation surrounding that trauma, producing corroborating evidence can often be difficult. This difficulty is aggravated by

One Survivor's Story: Ruth Moore

Ruth Moore is among the tens of thousands of veterans who have spent years fighting for the disability benefits they deserve and need because of the devastating mental health effects of military sexual trauma. After joining the Navy, Ruth Moore was raped twice by her supervisor. When she looked for help and support within the military for the resulting physical and mental suffering, she found only denial and betrayal.

First, the Navy did not prosecute the perpetrator. Second, VA repeatedly denied her claims for disability compensation for PTSD, despite a medical diagnosis and other documentation she provided. VA said there was not enough evidence to prove the rape. In other words, VA required extra evidence simply because Ruth Moore's PTSD claim was linked to MST. VA's discriminatory demand left her without compensation, homeless, and suicidal. It took years, and the strong support of veterans advocates, for VA to recognize Ruth Moore's claim.

Today, many vulnerable veterans are fighting the same fight against VA all alone.

the fact that, as of December 2011, DOD had a policy of destroying records of restricted reports of MST after only five years.¹⁷ Moreover, VA benefit adjudicators often fail to give adequate weight to the evidence that MST survivors do produce.¹⁸ As a result, survivors of MST are often unable to satisfy the very high standards required for them to secure disability benefits for their mental health conditions. Betrayed once by their fellow soldiers, survivors of MST are betrayed again by a disability compensation system that makes unreasonable evidentiary demands and often unjustly denies the benefits they need.

VA is fully aware of the challenges MST survivors face, and yet the agency has refused to alter the regulation to put MST survivors on equal footing with veterans who suffer from PTSD for reasons such as combat or fear of terrorist activity. VA has, however, issued guidance to VAROs on how corroborating evidence such as behavioral changes following the alleged sexual trauma should be treated.¹⁹ These are important steps towards improvement and may account for some of the improvement in recent years. But as the data make clear, they have not been sufficient to put MST survivors on level ground with other PTSD disability claimants.

II. WHAT THE DATA REVEAL

A. An Overview of MST-Related Mental Health Disability Benefit Claims

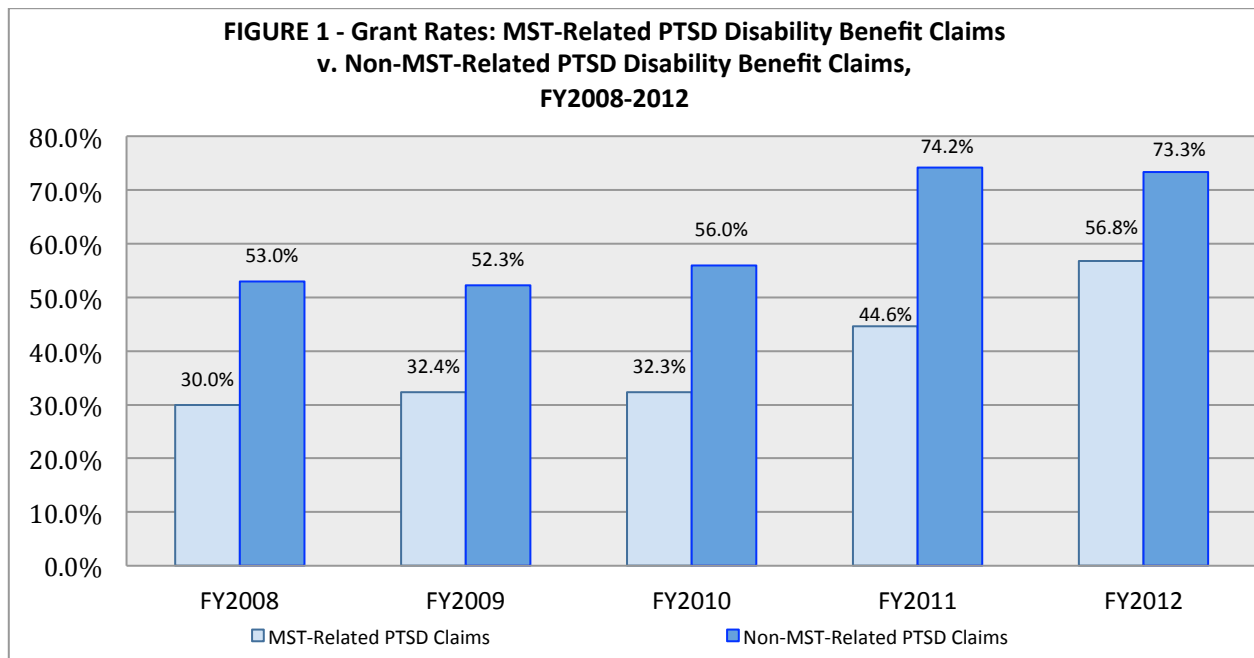
VA released data including gender-specific counts for each fiscal year between 2008 and 2012 of granted or denied disability benefit claims from unique claimants for four mental health conditions arising from MST: PTSD, generalized anxiety disorder, anxiety disorder not otherwise specified, and major depressive disorder. See Part IV for a fuller discussion of the dataset and the methodology employed to analyze the data.

These data reveal that from fiscal year 2008 to 2012, 15,862 veterans filed VA disability benefit claims for PTSD related to MST. During this same time period, a far smaller number of veterans brought disability benefit claims for major depressive disorder (331), anxiety disorder not otherwise specified (116), and generalized anxiety disorder (57) related to MST.

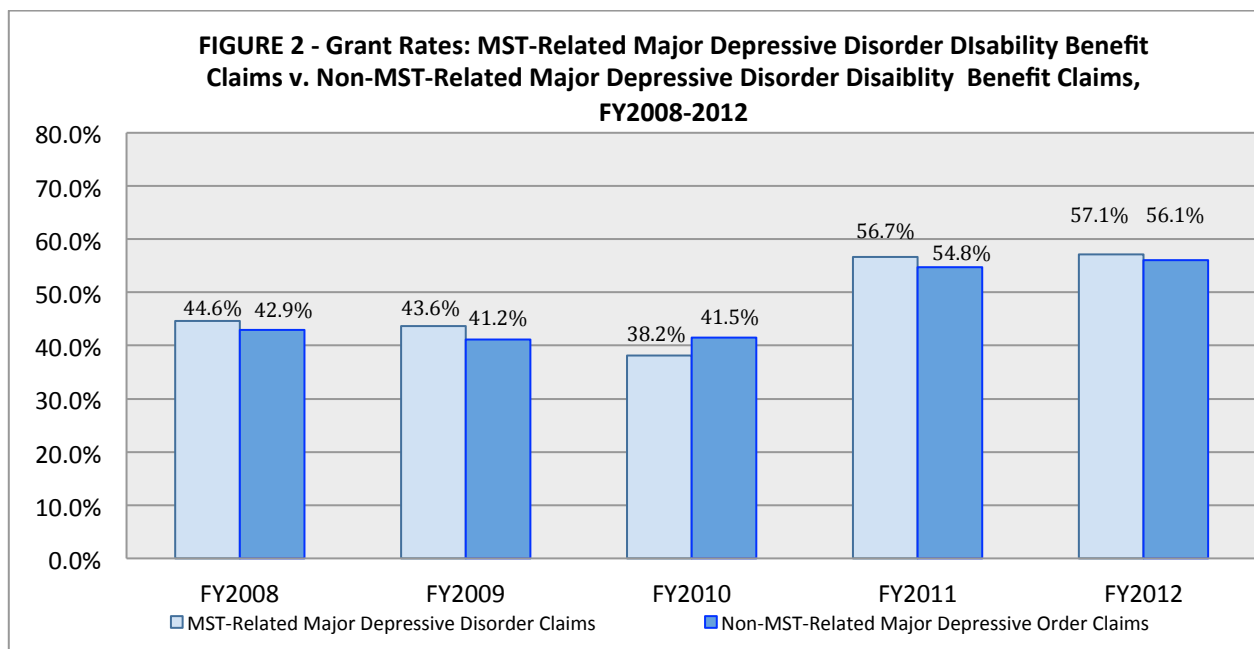
Female veterans were disproportionately represented among claimants for benefits for PTSD arising from MST. Of the nearly 16,000 veterans making MST-related PTSD disability benefit claims during this five-year period, 66.1% were female veterans. By contrast, female veterans accounted for only 4.6% of the claimants for disability benefits for PTSD related to causes other than MST during this same time period.

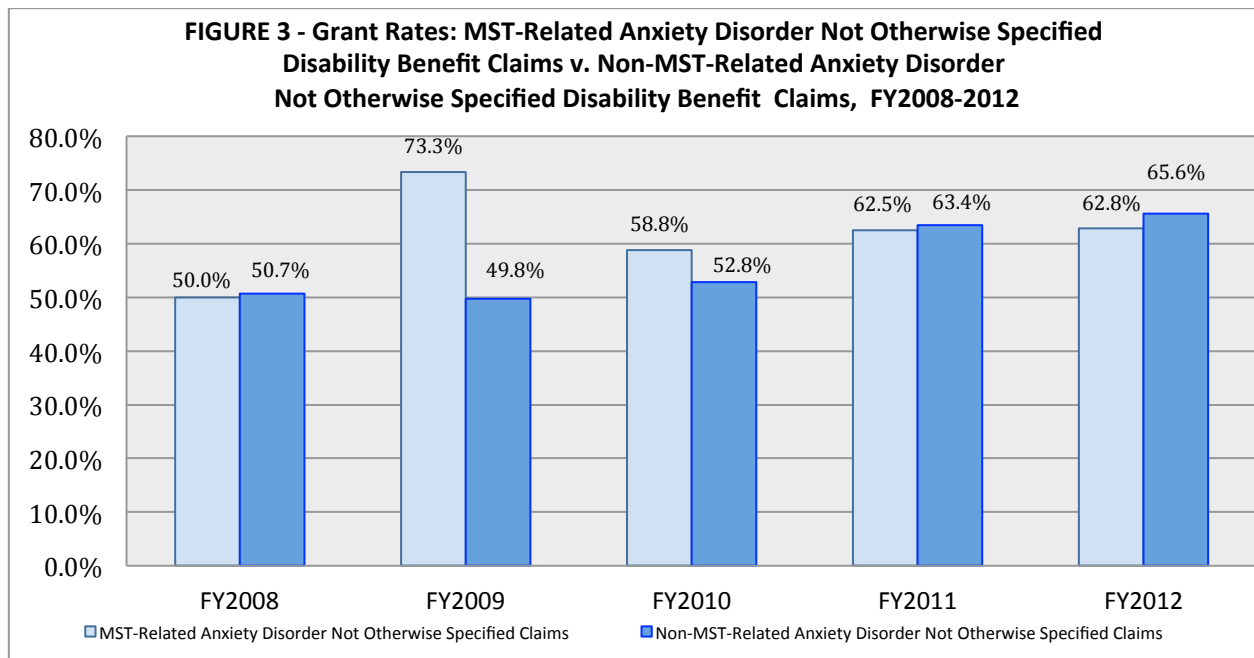
B. Comparing the Success of VA Disability Benefit Claims for MST-Related and Non-MST-Related Mental Health Disorders

Figures 1, 2, 3, and 4 on the following pages compare the rates at which VA granted disability benefit claims for veterans suffering from PTSD, major depressive disorder, anxiety disorder not otherwise specified, and generalized anxiety disorder arising from MST and veterans suffering from these same conditions unrelated to MST in fiscal years 2008-2012.



As Figure 1 above indicates, the grant rate for disability benefit claims for PTSD related to MST has lagged behind the grant rate for PTSD unrelated to MST every year for which VA provided data. The grant rate for MST-related PTSD disability benefit claims has improved from 32.3% in 2010 to 44.6% in 2011 and 56.8% in 2012, perhaps as a result of improved training efforts for VARO claims processors. However, VA still grants MST-related PTSD disability claims at a rate well below the rate at which it grants claims for PTSD unrelated to MST. In 2011, VA granted disability benefit claims for PTSD unrelated to MST at a rate 29.6 percentage points greater than the rate at which it granted claims for PTSD related to MST. In 2012, the gap between the grant rates narrowed but remained significant, with VA granting disability benefit claims for PTSD unrelated to MST at a rate 16.5 percentage points greater than the rate at which it granted MST-related PTSD disability benefit claims.





As Figures 2 and 3 above indicate, there is no such disparity in the rate at which VA grants disability benefit claims for MST-related major depressive disorder and MST-related anxiety disorder not otherwise specified when compared with the rates at which VA grants claims for these same conditions unrelated to MST. The annual grant rates for claims for MST-related major depressive disorder and MST-related anxiety disorder not otherwise specified have either lagged behind the grant rates for these same conditions unrelated to MST by very small margins or have exceeded the grant rates for claims unrelated to MST.

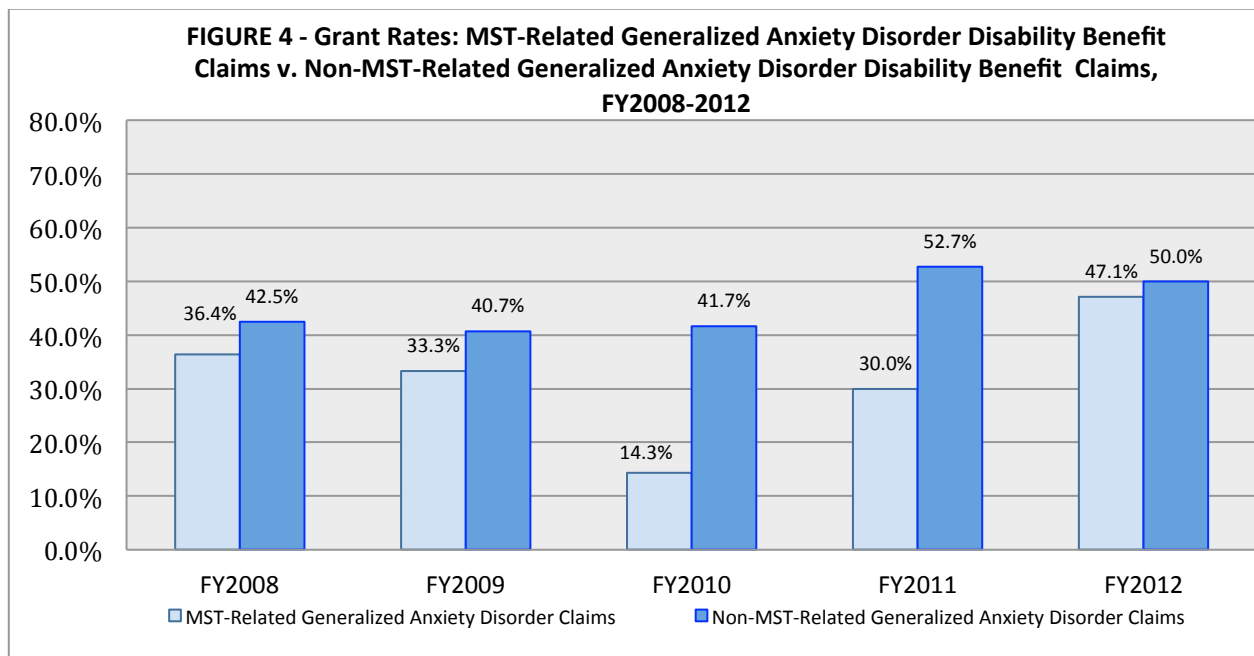


Figure 4 above presents claims findings for generalized anxiety disorder. Although it reveals large disparities in the grant rates in fiscal years 2010 and 2011, the numbers of MST-

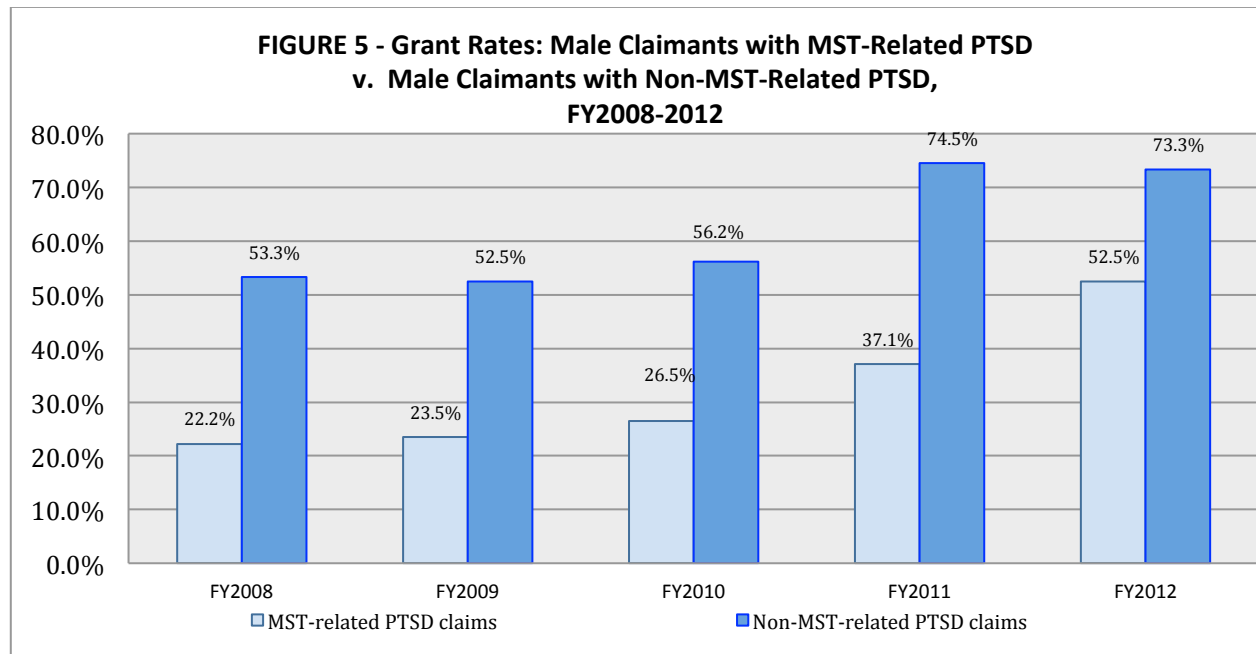
related claims were so small—7 and 10 claims from unique veterans in 2010 and 2011, respectively—that it is not possible to draw meaningful comparisons between the grant rates for claims for generalized anxiety disorder related to MST and those unrelated to it.

C. A Closer Look at PTSD Claims Related to Military Sexual Trauma

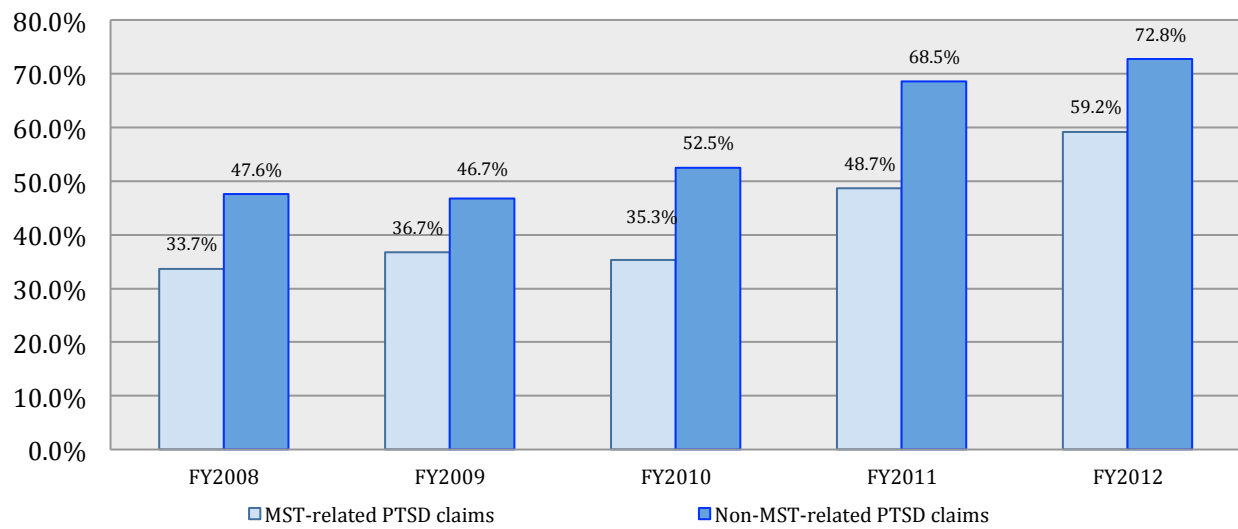
Because of the relatively large number of MST-related PTSD disability benefit claims and the significant margins separating the rates at which VA granted these claims and claims for PTSD unrelated to MST in fiscal years 2008-2012, a closer look at the PTSD data is warranted. The VA datasets allow for analysis based on the gender of the claimant and the VARO where the claim was adjudicated. Consideration of each of these factors illuminates important trends in the grant rates for the PTSD claims of MST survivors.

1. Variation in Treatment of MST-Related PTSD Claims by Gender

Figures 5 and 6 below break down the MST-related and non-MST-related PTSD claims by the gender of the claimant. This analysis reveals that male survivors of MST face particular difficulty in securing disability benefits. Figure 5 shows that in every fiscal year from 2008 to 2011, more than 27 percentage points separated the grant rate for male veterans claiming disability benefits for PTSD related to MST and the grant rate for male veterans claiming disability benefits for PTSD arising from other causes. This gap narrowed slightly (to 21.8 percentage points) in fiscal year 2012. These large margins for every year in the dataset likely reflect the greater evidentiary hurdles that MST survivors face in proving that their stressor is service-connected when compared to veterans who suffer PTSD from combat or fear of hostile military activity, for example. Moreover, the significant disparities in the MST-related grant rates for male claimants and female claimants also strongly suggest that gender bias is at work in the adjudication of MST-related PTSD claims.

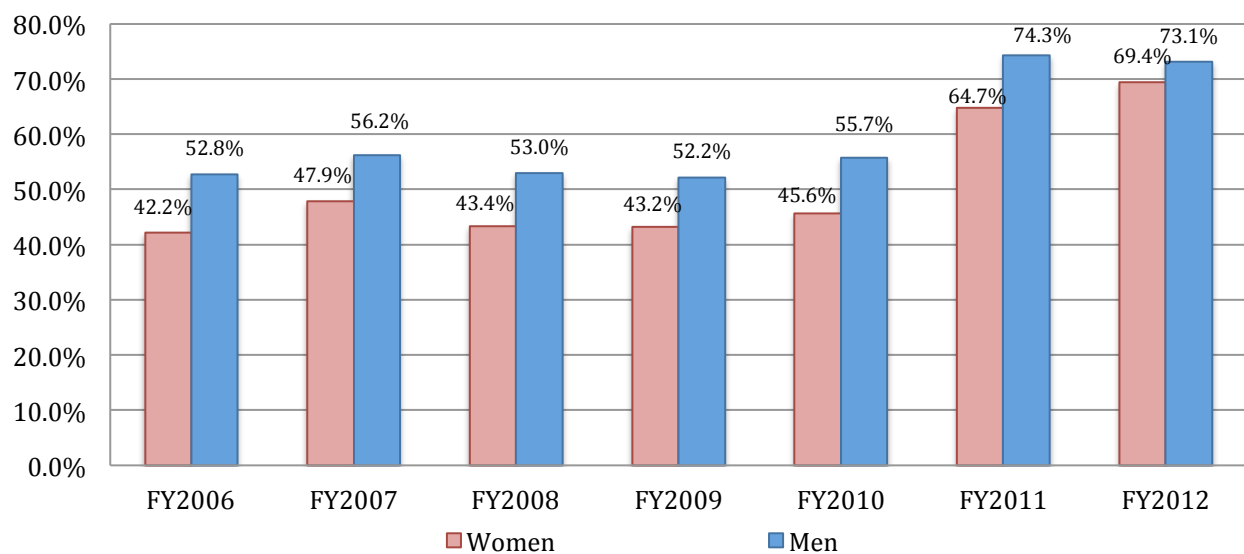


**FIGURE 6 - Grant Rates: Female Claimants with MST-Related PTSD
v. Female Claimants with Non-MST-Related PTSD,
FY2008-2012**



Female MST survivors claiming PTSD benefits fared better on average than male MST survivors; however, because MST claims account for such a large portion of PTSD claims brought by women (between 19.2% and 39.9% each year from 2008-2012) and because two-thirds of MST-related PTSD benefit claimants are women, the gaps in the rates for MST-related PTSD benefits and non-MST-related PTSD benefits disparately impact female veterans suffering from PTSD as a group. This impact is reflected in the statistically significant gender gap in the grant rates for overall PTSD claims. The grant rate for PTSD claims filed by female veterans lagged behind the grant rate for claims filed by male veterans each year from 2006 to 2012 (Figure 7 below).

FIGURE 7 - All PTSD Claims: Grant Rate by Gender, FY2008-2012



2. *Geographic Disparity in Treatment of MST-Related PTSD Disability Claims*

The data VA provided for each VA regional office (VARO) show striking variations in the success of MST-related PTSD disability benefit claims from one VARO to another. The data also reveal that as recently as 2012, when the national grant rate for MST-related PTSD claims had risen and the gap between the grant rates for MST-related PTSD claims and other PTSD claims had narrowed nationally and at most VAROs, some regional offices continued to grant MST-related PTSD claims at rates far below the national grant rate, and far below the rates at which they were granting claims for PTSD unrelated to MST.

WORST OFFENDERS:

Figures 8a-e below show the regional offices that considered **at least 40** MST-related PTSD disability benefit claims in fiscal years 2008-2012 and granted those claims at the lowest rates nationwide.²⁰

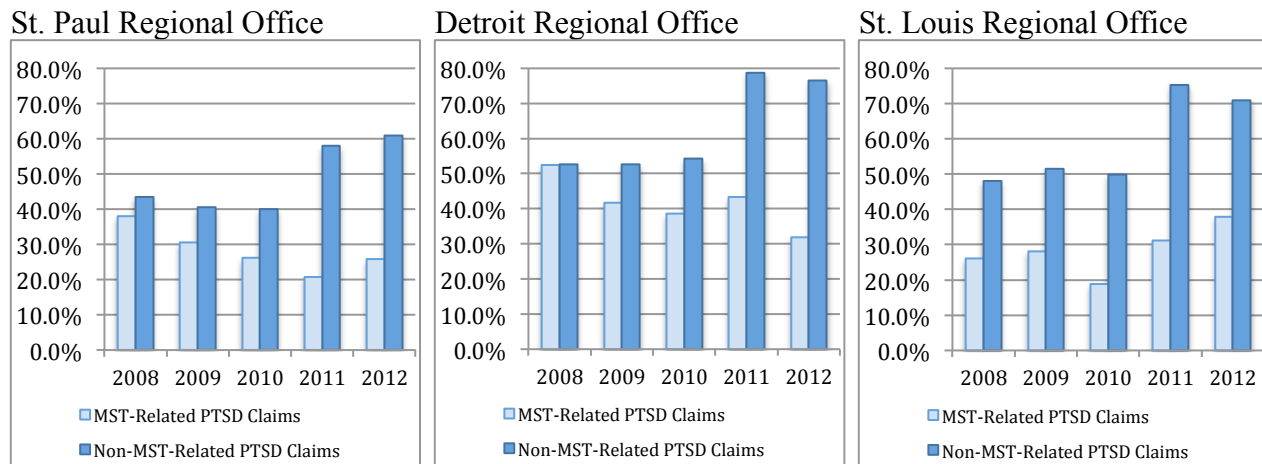
FIG. 8a: FY2008			FIG 8b: FY2009			FIG 8c: FY2010		
VARO Number and Location	MST-Related PTSD Claims	Grant Rate	VARO Number and Location	MST-Related PTSD Claims	Grant Rate	VARO Number and Location	MST-Related PTSD Claims	Grant Rate
320 Nashville, TN	48	14.6%	306 New York, NY	41	14.6%	331 St. Louis, MO	85	18.8%
319 Columbia, SC	62	19.4%	322 Montgomery, AL	43	16.3%	320 Nashville, TN	122	18.9%
351 Muskogee, OK	64	20.3%	402 Togus, ME	41	17.1%	322 Montgomery, AL	57	21.1%
325 Cleveland, OH	68	20.6%	351 Muskogee, OK	66	18.2%	351 Muskogee, OK	69	23.2%
349 Waco, TX	98	21.4%	320 Nashville, TN	53	18.9%	345 Phoenix, AZ	107	23.4%
310 Philadelphia, PA	57	24.6%	310 Philadelphia, PA	76	21.1%	340 Albuquerque, NM	51	23.5%
345 Phoenix, AZ	44	25.0%	344 Los Angeles, CA	48	22.9%	344 Los Angeles, CA	79	24.1%
331 St. Louis, MO	69	26.1%	348 Portland, OR	86	25.6%	325 Cleveland, OH	123	24.4%
317 St. Petersburg, FL	141	27.0%	345 Phoenix, AZ	62	25.8%	316 Atlanta, GA	69	24.6%
346 Seattle, WA	70	28.6%	350 Little Rock, AR	54	27.8%	328 Chicago, IL	95	25.3%

FIG 8d: FY2011			FIG 8e: FY2012		
VARO Number and Location	MST-Related PTSD Claims	Grant Rate	VARO Number and Location	MST-Related PTSD Claims	Grant Rate
335 St. Paul, MN	96	20.8%	335 St. Paul, MN	93	25.8%
327 Louisville, KY	40	27.5%	329 Detroit, MI	154	31.8%
351 Muskogee, OK	40	27.5%	331 St. Louis, MO	87	37.9%
350 Little Rock, AR	49	28.6%	334 Lincoln, NE	46	39.1%
320 Nashville, TN	71	29.6%	323 Jackson, MS	51	43.1%
314 Roanoke, VA	72	30.6%	350 Little Rock, AR	90	43.3%
341 Salt Lake City, UT	88	30.7%	322 Montgomery, AL	90	44.4%
331 St. Louis, MO	45	31.1%	341 Salt Lake City, UT	69	44.9%
322 Montgomery, AL	56	37.5%	345 Phoenix, AZ	89	46.1%
348 Portland, OR	82	41.5%	402 Togus, ME	54	48.1%

Because of their low grant rates, several of these offices merit a more in-depth look:

- The **St. Paul Regional Office** (MN) has a particularly bad record on MST-related PTSD disability benefit claims in recent years, granting the lowest percentage of these claims of any VARO in 2011 and 2012.
 - The office's 2012 grant rate for MST-related PTSD disability benefit claims (25.8%) was an improvement over the 2011 grant rate (20.8%), but overall there has been a net decrease of 12.3 percentage points in the grant rate for MST-related PTSD claims at this office from 38.1% in 2008 to 25.8% in 2012.
 - In 2012, when most VAROs made progress in closing the gap between MST-related PTSD disability benefit grant rates and non-MST-related PTSD disability benefit grant rates, the discrepancy at the St. Paul Regional Office was a remarkable 35.1 percentage points.
 - The discrepancy in the grant rates at the St. Paul Regional Office actually grew each year from 2008 to 2011, from only 5.4 percentage points in 2008 to 37.1 percentage points in 2011. The 2012 disparity of 35.1 percentage points is only a slight improvement over the 2011 rate and is still unacceptably large.
- The **Detroit Regional Office** (MI) has the second lowest grant rate of MST-related PTSD claims of any regional office processing 40 or more such claims in fiscal year 2012.
 - Similar to the St. Paul Regional Office, the grant rate of MST-related PTSD claims at the Detroit Regional Office has decreased dramatically over time, falling from 52.4% in 2008 to 31.8% in 2012.
 - At the same time, the discrepancy between the grant rates for MST-related PTSD claims and non-MST-related PTSD claims has grown. In 2012, the discrepancy at the Detroit Regional Office of 44.7 percentage points was greater than it had been at that regional office in any previous year in the dataset, and it was greater than any meaningful discrepancy at any other VARO across the country in 2012.²¹ The Detroit Regional Office granted 76.5% of non-MST-related PTSD benefits claims in 2012, but it granted only a paltry 31.8% of MST-related PTSD benefit claims.
- The **St. Louis Regional Office** (MO) takes third place among the VAROs with the worst records for granting MST-related PTSD benefit claims in 2012 among VAROS processing 40 or more such claims. It also holds the dubious distinction of ranking among VAROs with the worst records for four of the past five years.
 - Between 2008 and 2012, there has been a net increase in the grant rate for MST-related PTSD claims in St. Louis, up from 26.1% in 2008 to 37.9% in 2012.
 - However, the discrepancy between the grant rates for MST-related PTSD claims and non-MST-related claims also increased every year from 2008 to 2011, from a gap of 21.9 percentage points in 2008 to 44.2 percentage points in 2011.
 - In 2012 this gap narrowed slightly, with 33.0 percentage points separating the grant rate for MST-related PTSD disability benefit claims (37.9%) from the grant rate for non-MST-related PTSD disability benefit claims (70.9%).

FIGURE 9 - The Worst Offenders in FY2012 (among VAROs processing 40 or more MST-related PTSD benefit claims): Grant Rates for MST-Related PTSD Benefit Claims v. Non-MST-Related PTSD Benefit Claims, FY2008-2012



- The **Salt Lake City Regional Office (UT)** had above-average grant rates from 2008 to 2010, but the office's grant rate gradually dropped from 58.3% in 2008 to a low of 30.7% in 2011, earning it a spot among the lowest granters of MST-related PTSD benefit claims in 2011.
 - The Salt Lake City Regional Office maintained a place among the VAROs with the worst MST-related PTSD grant rates in 2012, granting only 44.9% of claims, compared to the nationwide grant rate of 56.8%.
 - Similar to the St. Paul and St. Louis Regional Offices, the gap between MST-related PTSD benefit grants and non-MST-related PTSD benefit grants grew dramatically between 2008 and 2011, from 19.2 percentage points in 2008 to a remarkable 49.9 percentage points in 2011, only to improve somewhat to a gap of 36.3 percentage point in 2012.
- The **Montgomery Regional Office (AL)** granted MST-related PTSD claims at a rate close to the nationwide grant rate in 2008, but it has granted these claims at a rate well below the nationwide grant rate every year since.
 - The grant rates for MST-related PTSD were consistently 28-30 percentage points behind the grant rates for non-MST-related PTSD claims at this office from 2009 to 2011; in 2012 this gap was somewhat smaller at 19.6 percentage points.

OFFICES MAKING NOTABLE IMPROVEMENTS:

- The **Nashville Regional Office (TN)** was repeatedly among the worst offices in granting MST-related PTSD disability benefits claims in fiscal years 2008-2011. The data for fiscal year 2012, however, show promising improvement in Nashville's grant rate for these claims.
 - As recently as fiscal year 2011, the grant rate was a dismal 29.6% for MST-related PTSD claims compared with 73.0% of non-MST-related PTSD claims, but in 2012

the office granted an impressive 71.1% of MST related claims compared to 72.6% of other claims.

- The **Los Angeles Regional Office (CA)** has also improved from being among the worst VAROs in terms of MST-related PTSD grant rates to being among the best.
 - The office did not make the list of worst offenders with 40 or more claims in 2008 because it processed only 39 claims. Yet its 2008 grant rate of 25.6% otherwise would have placed it on this list, as its grant rates of 22.9% and 24.1% did in 2009 and 2010, respectively.
 - In 2011, however, the office's MST-related PTSD benefit grant rate improved dramatically to 58.9% and again to 88.5% in 2012, making it one of the highest grant rates nationwide last year.

This analysis is not meant to suggest that other VAROs are not in need of improvement or that some other regional offices have not performed well. At many offices, however, the grant rates have risen and fallen according to no discernible patterns over the five years in the dataset, suggesting unpredictability in the disability claims process for MST survivors. Moreover, for many offices, the small numbers of MST-related claims considered make drawing meaningful information from the grant rates impossible given the large swing in the grant rate that a single grant or denial can cause. This analysis highlights some of the offices where either concerning or promising trends can be clearly discerned.

For further reference, the appendix to this report contains graphs and data tables for each VARO that include the numbers of MST-related PTSD claims and non-MST-related PTSD claims considered each year from 2008 to 2012 and the grant rate for those claims.

The key finding of this VARO analysis is that, to a much greater degree than is true of non-MST-related PTSD disability claims, the chances of success of a veteran's claim may have been—and may still be—significantly impacted by which regional office he or she applied to and when he or she applied. Such lack of uniformity nationwide creates unpredictability and injustice for former service members impacted by sexual trauma within the ranks. The compensation and care of those who have served this country should not depend on where in the country the service member lives once he or she returns to civilian life.

D. Noteworthy Trends in Overall Data for Mental Health Disability Benefit Claims

Analysis of the overall data on mental health disability claims released by VA was necessary to understand how VA handles MST-related mental health disability claims. This analysis revealed some striking trends that, while not the focus of this report, merit mention.

1. Growth in PTSD Disability Benefit Claims and in Grants in FY2011

Most dramatically, the data reveal that the number of PTSD claims increased by 58.7% from fiscal year 2010 to 2011. Compared to the 94,575 PTSD disability benefit claims filed in 2010, veterans filed 150,061 PTSD claims in 2011 and 157,635 claims in 2012. As Figure 11 indicates, the total number of claims denied remained roughly constant from fiscal year 2010 to 2012, but the number of granted claims increased dramatically. The grant rate for total PTSD claims rose from 55.1% in 2010 to 73.7% in 2011 and remained at 72.9% in 2012.

FIGURE 10 - Total PTSD Claims, FY2006-FY2012

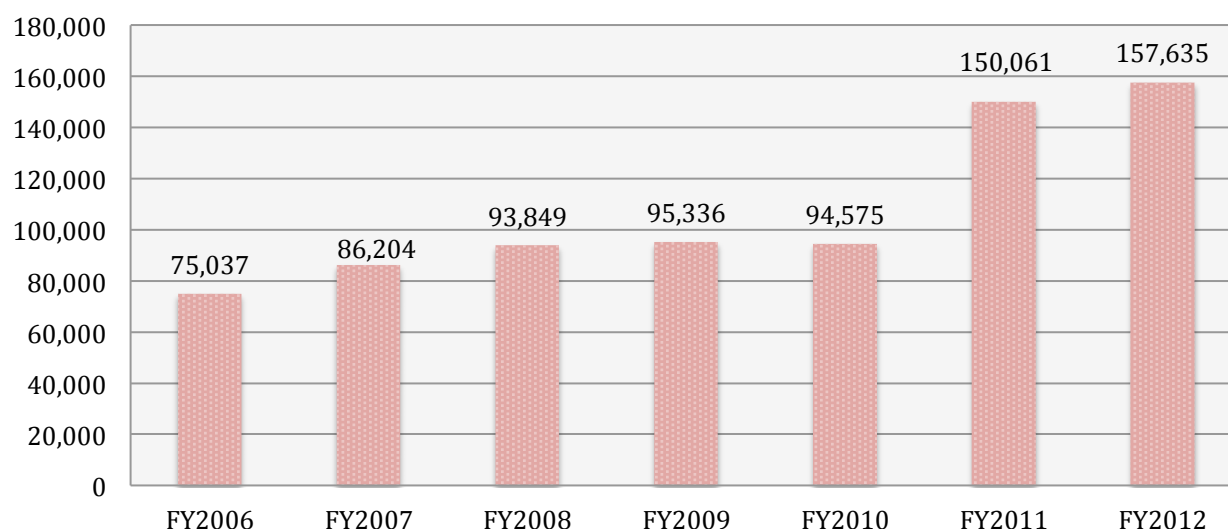
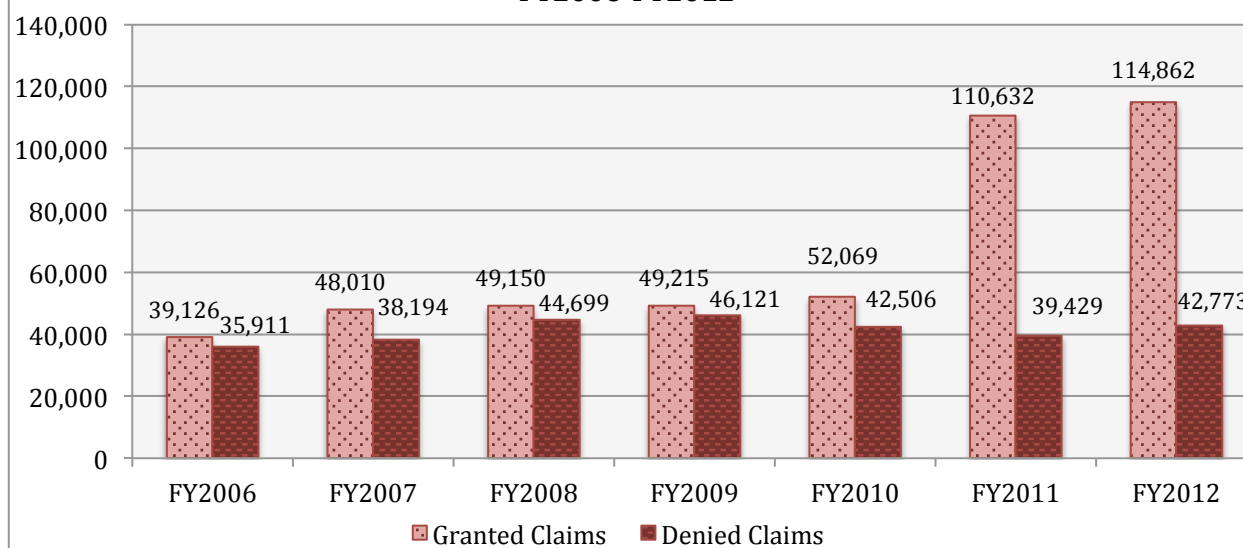


FIGURE 11 - Total PTSD Claims Granted and Denied, FY2006-FY2012



It is likely significant that the precipitous increase in both the total number of PTSD disability benefit claims made and the grant rate of PTSD benefit claims in fiscal year 2011 roughly coincided with the promulgation of a new, less demanding regulatory standard for proving service connection of PTSD arising from “fear of hostile military or terrorist activity.” This standard went into effect on July 13, 2010, one-and-a-half months before the start of fiscal year 2011.²² The data disclosed by VA in settlement of the FOIA litigation does not reveal whether this temporal correlation might also reflect causation. However, the fact that under the new regulation VA treated a veteran’s lay statement concerning the “fear of hostile military or terrorist activity” as grounds for re-opening and re-adjudicating previously denied claims²³ offers an obvious explanation for the large increase in granted PTSD claims in fiscal year 2011. It also suggests a

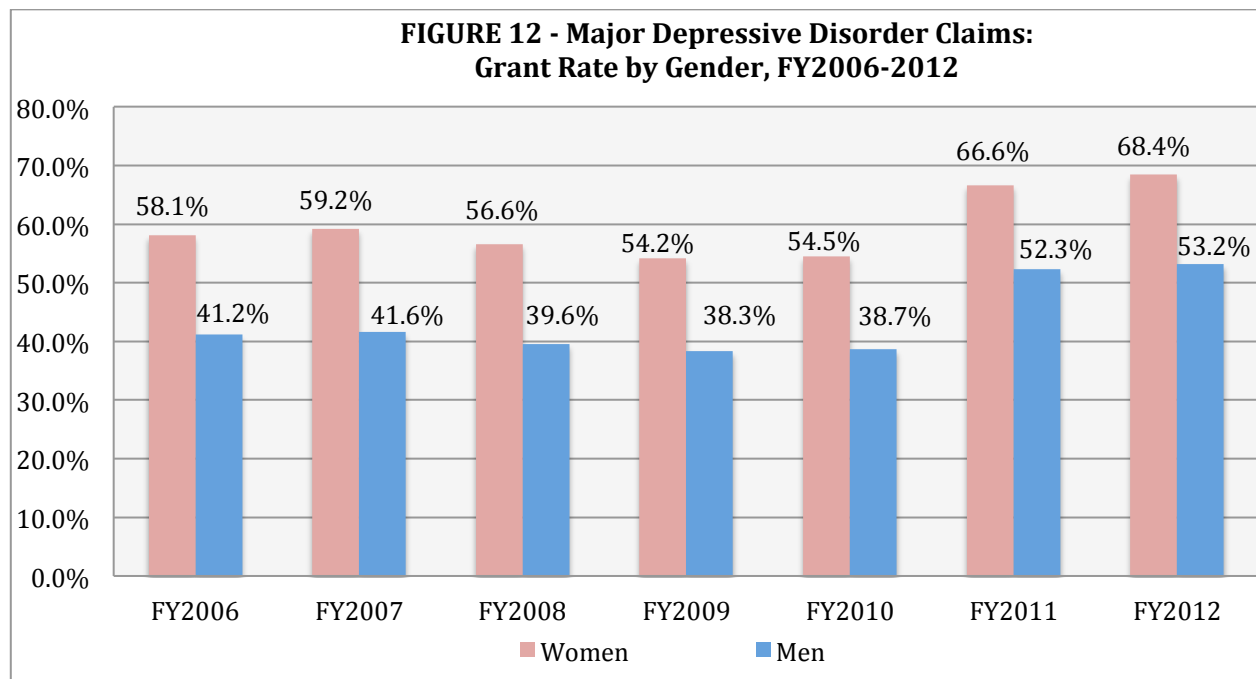
model for how VA should treat previously denied MST-related PTSD by altering the current regulation to put MST survivors with PTSD on equal footing with those who suffer PTSD for other reasons.

In June 2013, the Service Women’s Action Network and the Veterans Legal Services Clinic at Yale Law School, parties in the FOIA settlement leading to the release of this report’s data, submitted a rule-making petition requesting such a change.²⁴ At the time of the writing of this report, VA has yet to respond.

2. *Gender Disparity in Grant Rates for Major Depressive Disorder Claims*

The second noteworthy trend in the overall data for mental health conditions is the disparity in the grant rates for major depressive disorder benefit claims filed by women and men. As Figure 12 below indicates, VA granted male veterans’ disability benefit claims for major depressive disorder at a rate averaging 16.1 percentage points lower than the rate at which VA granted major depressive disorder disability claims from women veterans for fiscal years 2006-2012. Within the general population, women are more likely to suffer from major depressive disorder than men, and studies examining depression in Iraq and Afghanistan veterans have found that former service women are more likely to suffer from major depressive disorder than former service men.²⁵

However, this does not necessarily explain the gap in the grant rate for men and women seeking disability benefits. The denominator in the grant rate is not the population of veterans, but rather the population of veterans who seek out support for the disabling symptoms of major depression. More information on the reasons for the denial of the claims brought by both male and female veterans is necessary to understand this gender gap. VA did not provide clarifying data of this sort in conjunction with the FOIA suit.



III. POLICY RECOMMENDATIONS

This report's findings demonstrate an urgent need for a number of changes in how VA handles mental health disability benefit claims arising from rape, sexual assault, and sexual harassment in the military. Specifically, regulatory reform as well as improved training, oversight, transparency, and record keeping are necessary to resolve the overall discrimination, geographic variation, and apparent gender bias in the adjudication of MST-related PTSD claims that this report reveals.

A. *Recommendations*

Reform VA Regulations Regarding PTSD for In-Service Personal Assault:

- VA should use its PTSD combat regulation as a model to relax the evidentiary standard that applies to survivors of military sexual trauma under 38 C.F.R. § 3.304(f)(5).
 - The revised regulation should allow MST survivors to establish service-connection by lay testimony together with a diagnosis of PTSD from a certified psychiatrist or psychologist who also attests that the claimed stressor is adequate to cause PTSD.
 - VA should treat veterans' lay testimony as sufficient basis to re-adjudicate denied claims as it did following the July 2010 PTSD regulatory reforms.²⁶
 - To date, VA has argued that the current categories of acceptable corroborating evidence are appropriate and has refused to reduce the threshold evidentiary requirements that MST survivors must satisfy to qualify for compensation and pension medical exams.²⁷ The persistent and significant gaps between the annual grant rates for MST-related PTSD claims and for all other PTSD claims that this report reveals make abundantly clear that systemic regulatory reform is necessary to put MST survivors on equal footing with veterans who suffer from PTSD for other reasons.

Improve Training and Oversight of VAROs with Poor Records in Granting These Claims:

- VA should address both the wide variance in grant rates among VAROs and some VAROs' apparent discrimination against PTSD claims related to MST by conducting targeted training and strengthening oversight.
 - VA must retrain and/or replace senior staff at VAROs with the worst records in granting MST-related PTSD claims.
 - VA should inform the BVA of the discrepancies in grant rates among VAROs, and the BVA should review appeals of claims for MST-related PTSD denied by the worst-performing VAROs closely.
 - VA should not transfer MST-related PTSD claims to VAROs with bad track records in granting MST-related claims as part of its process of transferring claims among VAROs. This is often done in an effort to reduce the claims backlog.

- VA should analyze and release gender-specific data on MST-related PTSD disability benefit claims for each VARO on an annual basis.
 - While the nationwide gender-specific data on MST claims reveals that VA grants the PTSD benefit claims of male MST survivors at a significantly lower rate than it grants PTSD benefits claims of female MST survivors, it is unclear whether this is a systemic, nationwide problem or the result of gender bias at work in a small number of regional offices. As a first step, VA should conduct analysis to determine the scope of this problem.
 - If the VARO-specific data reveals that particular regional offices have large discrepancies between the grant rates for claims brought by men and by women, VA must retrain staff at these offices and monitor their performance on an ongoing basis.

Improve Transparency and Record Keeping:

- VA should release data annually on the grant rates for disability benefit claims for mental health conditions generally and for those related to MST specifically. This data should include a breakdown by gender as well as by VARO.
- VA should release more data on stressor categories in PTSD claims from 2009 onward so that the impact of the July 2010 regulatory change regarding PTSD relating to “fear of hostile military or terrorist activity”²⁸ can be more fully assessed.
- VA should release more extensive, gender-specific data on major depressive disorder disability claims and the reasons these claims are denied. This would allow researchers to examine possible explanations for this report’s finding that VA grants female veterans’ claims for major depressive disorder at a much higher rate than it grants male veterans’ claims.
- BVA must improve its record-keeping capacities within its database of appeals to accurately track the disposition of claims for disabilities that are based on MST. In response to the data requests at issue in this FOIA litigation, BVA revealed that current record-keeping practices do not allow BVA to accurately record when disabling conditions are allegedly the result of MST. Without adequate data, BVA cannot be held accountable, and the public cannot ensure that the denials MST survivors suffer at the VARO level are not also occurring in large numbers within BVA as well.

B. Current Legislative Opportunities for Reform

Congress should act swiftly to pass a body of important legislation that reforms VA regulations regarding disability claims based on PTSD for in-service personal assault, improves training and oversight of VAROs with poor records in granting MST-related claims, and improves VA transparency and record-keeping in its treatment of MST-based claims.

Legislation pending in Congress at the time of the writing of this report could help achieve some of the report's recommendations.

- One bill would legislatively relax the evidentiary standard that applies to MST-related PTSD claims and also introduce data reporting requirements for MST-related mental health disability claims (S. 294).²⁹
- Another bill includes a provision that would create a three-year pilot program to establish twelve VA claims adjudication centers of excellence by selecting the three highest performing VAROs and would also provide specialized training (H.R. 2088).³⁰ If the bill is passed, the Secretary of VA should ensure that treatment of MST-related mental health disability claims is a key consideration in evaluating and training VAROs.
- Another bill would establish a task force to assess retention and training of claims processors and adjudicators (H.R. 2528).³¹

IV. THE DATASET AND METHODOLOGY

In October 2010, SWAN, the ACLU Women's Rights Project, and the ACLU of Connecticut requested data on MST-related disability claims pursuant to the Freedom of Information Act, 5 U.S.C. § 552 (FOIA). When VA failed to respond in the time frame set out by law, the requesters filed suit in December 2010 against the agency and the U.S. Department of Defense (DOD) in federal court.³² When this suit did not result in full release of the data, the requesters filed an additional suit.³³ As a result of a settlement agreement executed in spring 2013,³⁴ VA provided aggregate data on disability benefit claims for mental health conditions related to MST and for mental health conditions more generally.³⁵ These data form the basis of this report and are available on the ACLU's website.³⁶

Specifically, the VA data on which this report is based include:

- (1) Annual, gender-specific counts for fiscal years 2006-2012 of all granted or denied disability benefit claims from unique claimants for four mental health conditions (Post-Traumatic Stress Disorder, generalized anxiety disorder, anxiety disorder not otherwise specified, and major depressive disorder);
- (2) Annual, gender-specific counts for fiscal years 2008-2012 of disability benefit claims from unique claimants for the same four mental health conditions associated with MST;
- (3) Annual counts for each VA regional office of granted and denied disability benefit claims from unique veterans for the four identified mental health conditions for fiscal years 2006-2012 and for these same four mental health conditions related to MST for fiscal years 2008-2012.³⁷

The grants and denials for male and female veterans as well as veteran claimants who did not indicate their gender were added in order to calculate the total number of grants and denials for each year.³⁸ Grant rates were then calculated based on the number of granted claims of a given type and the total number of claims of that type for each year. For the sake of comparing the grant

rates for MST-related mental health conditions and mental health conditions related to other causes, the number of MST-related claims (granted, denied, total) for a given mental health condition were subtracted from the corresponding number of overall claims (granted, denied, total) for that condition. Chi squared crosstabs analysis was run to test the significance of numerical findings.

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The Freedom of Information Act lawsuits against VA that resulted in the release of the data on which this report is based were litigated by: Taylor Asen, Will Bornstein, Doug Lieb, Sam Lim, Dana Montalto, Michael Samsel, Ivy Wang, and Randall Wilhite, law student interns in the Veterans Legal Services Clinic between 2010 and 2013, under the supervision of Professor Wishnie; Sandra Park and Lenora Lapidus of the ACLU Women's Rights Project; and Sandra J. Staub of the ACLU of Connecticut.⁴⁰

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- ¹ VA's official definition of MST is "psychological trauma, which in the judgment of a VA, mental health professional, resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while the Veteran was serving on active duty or active duty for training."
- ² See Service Women's Action Network, et al., v. U.S. Dept. of Defense, et al., No. 3:10-cv-1953 (D. Conn. May 10, 2013); Service Women's Action Network, et al., v. U.S. Dept. of Defense, et al., No. 3:11-cv-1534 (D. Conn. May 15, 2012).
- ³ "In-service" means while serving on active duty or active duty for training. National Center for PTSD, *Military Sexual Trauma*, U.S. Dept. of Veterans Affairs, <http://www.ptsd.va.gov/public/pages/military-sexual-trauma-general.asp> (last visited Oct. 24, 2013).
- ⁴ The Diagnostic and Statistical Manual of Mental Illness (DSM-V) identifies major depressive disorder as the co-occurrence of "[f]ive (or more) of the following symptoms (...) present during the same two-week period [that] represent a change from previous functioning[:]" 1) depressed mood most of the day, nearly every day; 2) markedly diminished interest or pleasure in activities most of the day, nearly every day; 3) significant weight loss when not dieting or weight gain, or decrease or increase in appetite nearly every day; 4) insomnia or hypersomnia; 5) psychomotor agitation or retardation; 6) fatigue or loss of energy nearly every day; 7) feelings of worthlessness or excessive or inappropriate guilt nearly every day; 8) diminished ability to think or concentrate or indecisiveness; and 9) recurrent thoughts of death or suicide. These symptoms rise to the level of major depressive disorder when they cause "clinically significant distress or impairment in social, occupation, or other important areas of functioning." The Diagnostic and Statistical Manual of Mental Disorders [hereinafter DSM-V], (Am. Psychiatric Ass'n 5th ed., 2013).
- ⁵ According to the DSM-V, the diagnosis of anxiety disorder not otherwise specified or "unspecified anxiety disorder" "applies to presentations in which symptoms characteristic of an anxiety disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the anxiety disorders diagnostic class. The unspecified anxiety disorder category is used in situations in which the clinician chooses *not* to specify the reason that the criteria are not met for a specific anxiety disorder, and includes presentations in which there is insufficient information to make a more specific diagnosis (e.g., in emergency room settings)." *Id.*
- ⁶ United States Department of Veterans Affairs, *Compensation*, <http://www.benefits.va.gov/compensation/> (last visited Oct. 27, 2013).
- ⁷ As of fiscal year 2011. National Center for Veterans Analysis and Statistics, Service-connected Disabled Veterans by Disability Rating Group: FY1986 to FY2011, U.S. Dept. of Veterans Affairs (Jan. 12, 2010), http://www.va.gov/vetdata/docs/Utilization/SCD_Ratings_2011_FINAL.pdf.
- ⁸ There are also VA regional offices in San Juan, Puerto Rico and in Manila, Philippines.
- ⁹ 38 U.S.C. § 5103 (2012).
- ¹⁰ Bd. of Veterans' Appeals, *Report of the Chairman: Fiscal Year 2011* 18 (2012), available at http://www.bva.va.gov/docs/Chairmans_Annual_Rpts/BVA2011AR.pdf.
- ¹¹ *Id.*
- ¹² Veterans Benefits Administration Reports, *2013 Monday Morning Workload Report*, U.S. Dept. of Veterans Affairs (Nov. 4, 2013), available at <http://www.vba.va.gov/reports/mmwr/>.
- ¹³ *Id.*
- ¹⁴ Steve Vogel, *VA Needs to Improve Accuracy of Claims Decisions, Vets Tell Congress*, Wash. Post Federal Eye (Sept. 10, 2013, 12:17 PM), <http://www.washingtonpost.com/blogs/federal-eye/wp/2013/09/10/va-needs-to-improve-accuracy-of-claims-decisions-vets-tell-congress/>.
- ¹⁵ See, e.g., Donna L. Washington et al., *Risk Factors for Homelessness Among Women Veterans*, 21 J. Health Care for Poor & Underserved 81, 87 (2010) (finding that that 53% of homeless women veterans were sexually assaulted while in service); Katherine M. Skinner et al., *The Prevalence of Military Sexual Assault Among Female Veterans' Administration Outpatients*, 15 J. Interpersonal Violence 291, 298-304 (2000).

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- ¹⁶ See 38 C.F.R. § 304(f)(2) (2013) for PTSD resulting from combat, § 304(f)(4) (2013) for PTSD resulting from prisoner of war status, § 304(f)(3) (2013) for PTSD resulting from “fear of hostile military or terrorist activity,” and § 304(f)(5) (2013) for PTSD resulting from personal assault and MST.
- ¹⁷ U.S. Deputy Sec’y of Def., *Directive-Type Memorandum (DTM) 11-062 – “Document Retention in Cases of Restricted and Unrestricted Reports of Sexual Assault”* 2-3 (Dec. 16, 2011), <https://www.hsdl.org/?view&did=727333>.
- ¹⁸ See Service Women’s Action Network & Vietnam Veterans of America, *Petition for Rulemaking to Promulgate Regulations Governing Service-Connection for Mental Health Disabilities Resulting from Military Sexual Assault: Submitted to the United States Department of Veterans Affairs*, (June 27, 2013), http://www.law.yale.edu/documents/pdf/vlsc_SWAN.pdf.
- ¹⁹ See Letter from Thomas J. Murphy, Dir., Compensation and Pension Service, to all VA Regional Offices, *Training Letter (TL) 11-05: Adjudicating Posttraumatic Stress Disorder (PTSD) Claims Based on Military Sexual Trauma (MST)* (Dec. 2, 2011), available at <http://www.vfwilserviceoffice.com/upload/TL%2011-05%20PTSD%20MST.doc>, attachment available at <http://www.vfwilserviceoffice.com/upload/TL%2011-05%20PTSD%20MST%20attachment.doc>.
- ²⁰ The VA data include information for each regional office identified by its three-digit VARO number. See Veterans Benefit Manual app. 12-A (Barton F. Stichman et al. eds., 2012). In addition to the 58 VAROs, the VA datasets also included claim-processing locations identified as 101, 282, 283, 397 and “HINS.” The grant rates at “HINS,” which processed a very large number of claims in 2008-2010, would place “HINS” on the list of worst VARO offenders in each of those years. However, it is not clear that “HINS” or any of the four other three-digit numbers listed above refers to an actual VARO. Instead “HINS”—and possibly also codes 282 and 293—may refer to the VA data processing center in Hines, IL. For this reason, “HINS” has not been included on the lists of worst offenders among VAROs. The data for “HINS” and for sites 101, 282, 283, and 397 are nevertheless included in the appendix for the information of researchers.
- ²¹ Technically the disparity between grant rates at the Washington, D.C. Regional Office was greater, but that office considered only one MST-related PTSD claim in FY2012, which it denied. This grant rate of 0% of one claim cannot be meaningfully compared to the 61.96% grant rate of the 326 non-MST-related claims this year.
- ²² 38 C.F.R. § 3.304(f)(3) (2013).
- ²³ See Letter from Thomas J. Murphy, Dir., Compensation and Pension Service, to all VA Regional Offices, *Training Letter (TL) 10-05 (Revised): Relaxation of Evidentiary Standard for Establishing In-Service Stressors in Claims for Posttraumatic Stress Disorder – 38 CFR § 3.304(f)(3)* (Nov. 15, 2010), available at <http://www.vfwilserviceoffice.com/upload/TL%2010%2005%20Revised%20PTSD.doc>; see also Veterans Benefit Manual 178 (Barton F. Stichman et al. eds., 2012) (citing VA Training Letter 10-15; however, Training Letter 10-05 seems to be the correct reference).
- ²⁴ See Service Women’s Action Network & Vietnam Veterans of America, *Petition for Rulemaking to Promulgate Regulations Governing Service-Connection for Mental Health Disabilities Resulting from Military Sexual Assault: Submitted to the United States Department of Veterans Affairs*, (June 27, 2013), http://www.law.yale.edu/documents/pdf/vlsc_SWAN.pdf.
- ²⁵ See, e.g., *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery* 98-100, 106 (Terri Tanielian & Lisa Jaycox eds., 2008), available at <http://www.rand.org/pubs/monographs/MG720.html>.
- ²⁶ 38 C.F.R. § 3.304(f)(3) (2013). See *supra* text accompanying note 18.
- ²⁷ See, e.g., *Legislative Hearing on H.R. 569, H.R. 570, H.R. 602, H.R. 671, H.R. 679, H.R. 733, H.R. 894 and H.R. 1405 Before the H. Comm. on Veterans’ Affairs*, 113th Cong. (2013) (statement of David R. McLenachen, Director, Pension and Fiduciary Service, U.S. Department of Veterans Affairs), available at <http://veterans.house.gov/witness-testimony/david-r-mclenachen>.
- ²⁸ 38 C.F.R. § 3.304(f)(3) (2013).

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- ²⁹ Ruth Moore Act, S. 294, 113th Cong. (2013), *available at* <http://www.gpo.gov/fdsys/pkg/BILLS-113s294is/pdf/BILLS-113s294is.pdf>.
- ³⁰ H.R. 2088, 113th Cong. (2013), *available at* <http://www.gpo.gov/fdsys/pkg/BILLS-113hr2088ih/pdf/BILLS-113hr2088ih.pdf>.
- ³¹ H.R. 2528, 113th Cong. (2013), *available at* <http://www.gpo.gov/fdsys/pkg/BILLS-113hr2528ih/pdf/BILLS-113hr2528ih.pdf>.
- ³² Service Women’s Action Network v. U.S. Dept. of Defense, No. 3:10-cv-1953 (D. Conn. May 10, 2013); *see also* Sandra S. Park & Rachel Natelson, *Exposing the Ugly Details of the Military Sexual Violence Epidemic*, ACLU Blog of Rights (Feb. 29 2012, 5:08 PM), <https://www.aclu.org/blog/womens-rights/exposing-ugly-details-military-sexual-violence-epidemic>.
- ³³ Service Women’s Action Network v. U.S. Dept. of Defense, No. 3:11-cv-1534 (D. Conn. May 15, 2012).
- ³⁴ Stipulation of Apr. 24, 2013, Service Women’s Action Network v. U.S. Dept. of Defense, No. 3:10-cv-1953 (D. Conn. May 10, 2013) (ECF No. 68).
- ³⁵ DOD continues to resist most aspects of the FOIA requests, and litigation against DOD is ongoing; however, DOD has produced selective data on reports of sexual harassment, sexual assault, and domestic violence across the armed services in partial fulfillment of the requests. SWAN, the ACLU Women’s Rights Project, and the ACLU of Connecticut are in the process of analyzing this data.
- ³⁶ *See* <https://www.aclu.org/va-sexualviolence>. VA provided more documents than the ones that are analyzed in this report, and all of the documents that VA provided are posted on the ACLU’s website for the use of researchers. This report focuses on the two documents that include data on grants and denials for mental health conditions overall and mental health conditions related to military sexual trauma, posted as Excel documents on the ACLU’s website.
- ³⁷ In the data for fiscal years 2008-2010, VA coded in-service sexual trauma as TRM/1 or TRM/2. The counts for these years include the number of mental health claims for each of the four conditions associated with one of these two trauma codes. From fiscal year 2011 onward, VA instead used PTSD-Personal Trauma (PTSD/3) with special issue basis Sexual Trauma/Assault (PTSD/10)/Sexual Harassment (PTSD/12) to code for in-services sexual trauma. The data for 2011 and 2012 include each of the four mental health conditions associated with one of these trauma codes. It is unclear whether this means that the claims for generalized anxiety disorder, anxiety disorder not otherwise specified, and major depressive disorder from 2011 and 2012 are only claims also associated with PTSD. VA did not provide further clarification, but because conditions other than PTSD are a secondary focus of this report, this is ultimately not central to the findings of this paper. Future researchers, however, should be aware of the coding change.
- ³⁸ Only a small number of claimants declined to indicate their gender each year. For PTSD claims related to MST, between 0.8% and 1.2% of the claimants did not indicate their gender each year from FY2008-2012. For PTSD claims related to other causes between 1.5% and 1.8% of claimants did not indicate their gender.
- ³⁹ This paper reflects the views of its authors and the organizations that are publishing it. It does not represent the views of Yale Law School.
- ⁴⁰ *See* Service Women’s Action Network, et al., v. U.S. Dept. of Defense, et al., No. 3:10-cv-1953 (D. Conn. May 10, 2013); Service Women’s Action Network, et al., v. U.S. Dept. of Defense, et al., No. 3:11-cv-1534 (D. Conn. May 15, 2012).